DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03		(X3) DATE SURVEY COMPLETED		
		155355	B. WING			R 05/13/2016	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety		{K 0)00) }		
	Survey Date: 05/13/1	6					
	Facility Number: 000 Provider Number: 15 AIM Number: 100275	5355					
	Rehabilitation was for Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a	2 CFR Subpart 483.70(a), and the 2000 edition of the on Association (NFPA) 101, C) and 410 IAC 16.2. eyed with Chapter 19,					
	Building 01, a two sto of Type II (222) const story, fully sprinklered construction with a pa 03, a one story, fully s V (111) construction. system with smoke de spaces open to the co operated smoke deter	ctors in all resident rooms. acity of 157 and had a					
		ents have customary access areas providing facility					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03		(X3) DATE SURVEY COMPLETED		
		155355	B. WING			R 05/13/2016	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 600 W WASHINGTON AVE COUTH BEND, IN 46619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULE TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
{K 000}	A Post Survey Revisic Code Recertification as conducted on 03/15/1 Indiana State Departriaccordance with 42 C Survey Date: 05/13/2 Facility Number: 000 Provider Number: 15 AIM Number: 100275 At this PSR survey, V Rehabilitation was for Requirements for Part Medicare/Medicaid, 4 Life Safety from Fire: National Fire Protectic Life Safety Code (LSC Building 01 was surve Existing Health Care This facility consists of Building 01, a two story, fully sprinklered construction with a part of Type II (222) const story, fully sprinklered construction with a part of the construction. System with smoke despaces open to the conperated smoke determed the facility has a cap census of 90 at the time.	leted on 05/17/16 - DA It (PSR) to the Life Safety and State Licensure Survey 6 was conducted by the ment of Health in FR 483.70(a). West Bend Nursing and und in compliance with ticipation in 2 CFR Subpart 483.70(a), and the 2000 edition of the on Association (NFPA) 101, C) and 410 IAC 16.2. eyed with Chapter 19, Occupancies. of three connected buildings: rry, fully sprinklered building ruction; Building 02, a one dibuilding of Type V (000) artial basement and Building sprinklered building of Type The facility has a fire alarm election in the corridors, in orridors and battery ctors in all resident rooms. acity of 157 and had a	{K 0	00}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03		(X3) DATE SURVEY COMPLETED	
		155355	B. WING			R 05/13/2016	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			•	46	TREET ADDRESS, CITY, STATE, ZIP CODE 500 W WASHINGTON AVE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
{K 000}	Continued From page 2 were sprinklered. All areas providing facility services were sprinklered.		{K 000}				
{K 000}	Quality Review completed on 05/17/16 - DA INITIAL COMMENTS		{K 0	00}			
	Code Recertification						
	Survey Date: 05/13/1	16					
	Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420						
	Rehabilitation was for Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protecti Life Safety Code (LSC	22 CFR Subpart 483.70(a), and the 2000 edition of the on Association (NFPA) 101, C) and 410 IAC 16.2. eyed with Chapter 19,					
	Building 01, a two sto of Type II (222) const story, fully sprinklered construction with a pa 03, a one story, fully s V (111) construction. system with smoke do spaces open to the co	of three connected buildings: bry, fully sprinklered building ruction; Building 02, a one d building of Type V (000) artial basement and Building sprinklered building of Type The facility has a fire alarm etection in the corridors, in bridors and battery ctors in all resident rooms.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING 01, 02, 03			(X3) DATE SURVEY COMPLETED	
155355			B. WING			R 05/13/2016		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				4600	EET ADDRESS, CITY, STATE, ZIP CODE D W WASHINGTON AVE JTH BEND, IN 46619		10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION S		HOULD BE COMPLETI		
{K 000}	The facility has a cap census of 90 at the till All areas where resid were sprinklered. All services were sprinkle	acity of 157 and had a me of this survey. ents have customary access areas providing facility	{K 0	00}				